UNIFORM EXAMINATION PROGRAM FOR

CONTRACT YEAR 2004

ADJUSTED COMMUNITY RATE SUBMISSIONS

Name of M+C Organization: _____

M+C Organization's H Number: _____

Contract Period: _____

Type of Plan(s): _____

Names of Contact Personnel at M+C Organization:

_____

M+C Organization Address: _____

_____

_____

Entrance Conference Date:

_____

Exit Conference Date:

_____

Audit Manager:

_____

UNIFORM EXAMINATION PROGRAM FOR
ADJUSTED COMMUNITY RATE SUBMISSIONS

INTRODUCTION

Federal regulations require each Medicare+Choice (M+C) organization, (M+C was designated Medicare Advantage (MA) per MMA Act) to compute a separate adjusted community rate (ACR) for each M+C coordinated care, private fee-for-service, or religious fraternal benefit health care plan offered to Medicare beneficiaries. To compute the ACR, an M+C organization with non-Medicare enrollees calculates an initial rate for the contract period that represents the average premium that it would charge its general non-Medicare-eligible population for the same type of plan (e.g., health maintenance organization). In addition, the organization must compute, if possible, corresponding information for the base period. The ACR worksheet will use the initial rate and the base period data to produce non-Medicare trend values. The worksheet then multiplies the non-Medicare trend values by Medicare base period costs, if available, to provide a projection of contract year costs. M+C organizations without non-Medicare enrollees and/or without Medicare enrollees in the base period must follow a different methodology. Either way, the ACR methodology is flexible enough to allow M+C organizations to modify the calculations to reflect their best estimate of projected costs for the contract year.

M+C organizations must submit such calculations on the worksheets that accompany CMS's ACR instructions and must supply additional supporting material as requested. All data submitted as part of the ACR process are subject to audit by CMS or any person or organization CMS designates as its representative as required by 42 CFR 422.502(d), (e), and (f). MMA proposes to re-designate existing 422.502 to 422.504. The management of the M+C organization offering the plan certifies the ACR proposal (ACRP) as follows:

Certification

I hereby certify that I have examined the accompanying Adjusted Community Rate proposal and attached worksheets for the contract period identified in Part IA, line 7. To the best of my knowledge and belief, this proposal contains true and correct statements prepared from the books and records of the contracting organization in accordance with applicable instructions, except as noted. In addition, I certify this proposal agrees with the Plan Benefit Package form submitted for the same contract period.

_____ _____

Chief Executive Officer Date

_____ _____

Chief Financial Officer Date

Management's certification provides the written basis of an assertion that permits the auditor(s) to express a conclusion about management's assertion after the auditor(s) perform the appropriate attestation procedures.

Requirement for Periodic Audits

To fulfill its responsibilities to manage the M+C program (Part C of Medicare), including the management of the ACR proposal process, CMS conducts various audits of M+C organizations and the documents they submit under Part C. Those audits include the periodic (annual) audits, required by law (section 1857 (d)(1) of the Balanced Budget Act of 1997) and continued by the MMA, of one-third of all M+C organizations offering M+C plans.

Application of this Examination Program

As stated above, CMS is required to examine annually at least one-third of all M+C organizations offering M+C plans. This Uniform Examination Program for Adjusted Community Rate Proposals is designed to facilitate the examinations.

Auditors should use this document as a tool to develop their own examination program. A final audit plan for any specific M+C organization is dependent on criteria such as:

- Type of plan: (e.g., provider sponsored organization);
- Scope of audit: (e.g., broad or targeted);
- Organizational characteristics: (e.g., new, no non-Medicare enrollees, profit vs. non-profit); and
- Audit objectives mutually agreed upon by CMS and the auditor(s).

Auditors should familiarize themselves with CMS's instructions for completing both 2004 ACR proposals (thus the MMA submission) and with other relevant material.

SECTION I: THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION (MMA) ACT OF 2003

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, which contains several provisions affecting the Medicare+Choice Program, was enacted on December 8, 2003. MMA increased the capitation payments to M+CO's, which were to be effective March 1, 2004. The new rates were developed by CMS' Office of the Actuary and announced on January 16th, 2004. M+COs that renewed their contract for 2004 were offered multiple options to use the additional payment. These M+CO's were required to submit a revised ACRP by January 30, 2004 to reflect the increase in payment and show how the increase would be used. See the MMA instructions and Q&As posted on CMS' website for more information.

In such mandatory resubmissions, M+C organizations could use the extra payment and make changes to their ACRP for one of the following MMA options:

- Reduce beneficiary premiums
- Reduce beneficiary cost sharing
- Enhance benefits
- Contribute to a benefit stabilization fund
- Stabilize or enhance beneficiary access to providers

In addition, M+C organizations could make the following changes not related to MMA:

- Update 2004 cost projections in Worksheet D (Expected Cost and Variation – Standard Benefit Package) to reflect effects from matters such as "run-out" of base period costs.
- Update demographic and enrollment projections used to calculate the average payment rate.
- Correct errors in previously approved ACRP(s)

On the other hand, in such mandatory resubmissions M+C organizations could not:

- Increase beneficiary premiums
- Increase beneficiary cost sharing (except as part of a benefit enhancement where the ACR value of increased cost sharing does not exceed the ACR value of the increase to the benefit)
- Reduce benefits
- Make any changes to the values in the approved ACR Worksheet B (Base period costs and Enrollment) or Worksheet B-1 (Financial Data) or to the non-Medicare base period costs on Worksheet A (Cover Sheet), lines 1-6, column a, Part IB.
- Increase administration costs unless the increase has a significant and direct relationship to stabilizing or enhancing beneficiary access to providers or is directly related to enhanced benefits.
- Increase additional revenue unless the increase directly relates to enhanced benefits.

New data elements were added in Worksheets A1 and D. A1 added an APR and PMPM catch-up payment value. D added a Medicare Discount Card – expected variation.

Data elements were revised in Worksheets A and E. Line 8 Part 1a in W/S A represented the Average Payment Rate and Catch-Up Payment. Line 9 Part 1a in W/S A represented the Contribution/Withdrawal-Stabilization Fund. Line 1, Part III in W/S A was the Medicare Part B premium. Line 1 in W/S E was the Average Payment Rate and PMPM Catch-up Payment. Line 10 in W/S E was the Contributions to/or Withdrawals from Stabilization Fund.

MMA related audit steps applicable to the relevant worksheets have been added to the Uniform Examination Program. The objective of any additional audit step directly related to MMA should be to verify that the M+CO properly allocated the use of the additional payment as permitted under MMA.

PLAN NAME: _____
M+C ORGANIZATION NUMBER: _____
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SECTION II: PLANNING

AUDIT OBJECTIVES:

1. To plan the proposed examination engagement:

   a. In accordance with the following pronouncements: generally accepted auditing standards (GAAS) and generally accepted governmental auditing standards (GAGAS), as prescribed by the Government Auditing Standards (1994 revision)

   b. In accordance with special directives and procedures as determined by CMS, and

   c. In a manner that is efficient and that meets CMS's objectives.

2. To plan the sections of the audit program in which contracted actuaries are required to participate:

   a. In accordance with the applicable Actuarial Standards of Practice (ASOP), as promulgated by the American Academy of Actuaries.

   b. In accordance with special directives and procedures as determined by CMS, and

   c. In a manner that is efficient and that meets CMS's objectives.

3. To appraise all source documents that may contribute to the understanding and evaluation of the M+C organization's development and submission of ACRPs. Those include any necessary information from the material that the M+C organization must provide under 42 CFR 422.502 (d), (e), and (f). MMA proposes to re-designate existing 422.502 to 422.504.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.

1. Review the M+C organization's ACRPs and document the following data:

   a. Type of Plan

      (1) For coordinated care plans:

         (a) Health maintenance organizations — HMO

         (b) Health maintenance organizations with point-of-service option — HMOPOS

         (c) Provider-sponsored organizations — PSO

         (d) Preferred provider plans — PPO

         (e) Other — CCOTH

      (2) For M+C private fee-for–service plans — PFFS

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AUDIT PROCEDURES:		Initial & Date	W/P Ref.
For M+C MSA plans – None should exist per section 1851 (b)(4)(A) of the Social Security Act	MSA		
(3) For other types of plans	OTHER		
(4) Religious fraternal benefit plans	RFB		
Type of Plan: _____		_____	_____
b. Determine if total enrollment can be identified by plan.		_____	_____
c. Ensure that the organization is submitting support for the CMS-approved version of each ACR worksheet.			
(1) Worksheet A – Cover Sheet		_____	_____
(2) Worksheet A1 – Service Area and Estimate of Annual Payment Rate		_____	_____
(3) Worksheet B – Base Period Costs, Revenue and Enrollment		_____	_____
(4) Worksheet C – Premiums & Cost Sharing		_____	_____
(5) Worksheet D – Expected Cost & Variation		_____	_____
(6) Worksheet F – Adjusted Community Rate for Optional Supplemental Benefits			
2. Acquire copies of CMS's approved ACRPs (ACR and PBP) from CMS and review the desk review findings.		_____	_____
3. Review, with CMS, the criteria for which the plan was selected for examination. Document CMS's inquiries to ensure that the specifics of the inquiries are included in the scope of the examination.		_____	_____
4. Complete the planning control document sections:			
a. Understanding the engagement.		_____	_____
b. Planning considerations.		_____	_____
c. Staffing and scheduling.		_____	_____
d. Planning conferences.		_____	_____
e. M+C organization correspondence.		_____	_____

PLAN NAME: _____
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AUDIT PROCEDURES:	Initial & Date	W/P Ref.
f. Obtain names and telephone numbers of key personnel from CMS	_____	_____
g. Provide CMS and the M+C organization written notice of the date of the survey, entrance conference, and exit conference and when the audit team will be on site performing the fieldwork. This is to ensure the availability of the M+C organization's staff to answer inquiries and to provide information.	_____	_____
5. Obtain and/or review the following items not already in CMS's possession. Maintain a current file.	_____	_____
a. An organization chart illustrating the ownership, operation, and organizations represented.	_____	_____
b. An overall description of the operation of the M+C organization's financial, medical delivery, and record-keeping systems.	_____	_____
c. List of agreements, (including marketing and management agreements), contracts, subcontracts, and franchises that affect the costs of health care services to the Medicare beneficiaries.	_____	_____
d. Supporting schedules used in the development of the ACR worksheets.	_____	_____
e. M+C organization's contract with CMS.	_____	_____
f. M+C organization's marketing materials.	_____	_____
g. Records of CMS disciplinary actions affecting the M+C organization, if applicable and necessary.	_____	_____
h. Any state filings (e.g., rate filings, orange blanks).	_____	_____
i. Base period year-end financial statements.	_____	_____
6. Determine if CMS has recently audited the M+C organization's ACR. If so, review the findings and working papers.	_____	_____
7. Review relevant material from The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.	_____	____ _____

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SECTION III: WORKSHEET A – COVER SHEET

AUDIT OBJECTIVES:

1. To test management's assertion that the non-Medicare cost information (Part IB, columns a and b, lines 1-6) is calculated as prescribed by CMS's instructions for completing the ACRP.

2. To determine whether executives of the M+C organization certified the ACRP.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. Compare the ACRP contract year as reported in the desk review file to the data reported in Part IA, line 7.	_____	_____
2. Request support for the base period and contract period components shown in Part IB, columns a and b, lines 1-6: collections/initial rate, direct medical care without reinsurance recoveries, reinsurance recoveries, administration, reinsurance premium, and additional revenue. Both the initial rate and base period collections (including the components) should include data for the same type of plan as the Medicare + Choice plan being priced in the ACR. Ensure that the calculations are reasonable. Detailed support for non-Medicare trend calculations is not necessary. A document referencing the trend used is sufficient (e.g., state rate filings,). Document findings and observations. NOTE: Document instances where an M+CO did not follow CMS's instructions as an observation, even though the reported ACR values were not materially affected.	_____	_____
3. Ensure that the certification statement is signed and dated by the chief executive officer, and the chief financial officer. See the ACR instructions for more information on signatures required for resubmitted ACRPs.	_____	_____
4. Verify the accuracy of the stabilization fund.	_____	_____
5. Verify the accuracy of the part B premium reduction.	_____	_____
6. MMA audit steps:		
a) Ensure the certification statement is signed and dated by the chief executive officer and chief financial officer. Each and every ACR submitted under the MMA must be signed.		
b) Review the cover letter and note any exceptions granted by CMS		
c) Verify that changes have not been made to the Base Period Collections and other components (Part IB, column a, lines 1-6)		
d) Determine if changes to values in the ACR have appropriate justification.	_____	

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SECTION IV: WORKSHEET A1 – SERVICE AREA AND ESTIMATE OF ANNUAL PAYMENT RATE

BACKGROUND:

Worksheet A1 is provided for two purposes: to identify the service area for the contract year of the M+C plan being priced in an ACR, and to calculate the plan's Average Payment Rate (APR). The 2004 Worksheet allowed for statutory changes in the phase-in of risk adjustment of payment rates for 2004. The payment rates for 2004 were 70 percent demographic factors and 30 percent risk adjustment. The worksheet allowed for the effects on payment rates of implementing a new comprehensive risk adjustment method (the CMS Hierarchical Condition Category model)

AUDIT OBJECTIVES:

1. To test management's assertion that the risk factor calculations are reasonable.
2. To determine whether management employed reasonable assumptions projecting plan membership and have included all appropriate types of enrollees.
3. To test management's assertion that any adjustments it makes to the worksheet are reasonable.
4. To test management's assertions that the APR is not materially misstated.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. Compare the projected Medicare average membership in columns p, q, and r to the CMS enrollment data for reasonableness. Verify that the total membership of all plans offered by the M+C organization is reasonably consistent with the total for the related H number. (That information will be provided by CMS.) Ensure that the projected enrollment is specific for each plan. Out-of-area enrollees should be included under state-county code 99999. ESRD and Hospice members should be included in the APR calculation, but may be included with the out-of-area members under state-county code 99999. Document findings.	_____	_____
2. Verify the CY 2003 actual monthly payment rates and any appropriate adjustments (i.e., to add back items CMS withheld from 2003 payments like user fees). Trace the data to the actual payment records from CMS's Automated Plan Payment System and those recorded on the organization's general ledger. Verify any adjustments. Document any discrepancies.	_____	_____

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3. Review the plan-level adjustments. Possible plan-level adjustments could include, but are not limited to, adjustments from H#-level to plan-level payments or adjustments for differences in expected demographics. Adjustments should be made to more closely approximate the estimated payment the M+CO expects to receive from CMS for that plan. Comment upon the reasonableness of the assumptions. _____ _____

4. Verify the county risk payment rates. Compare the payment rates in the approved worksheet to the rate table on CMS's Web site. Document any differences. _____ _____

5. Verify the demographic and risk calculations. If the current year risk score changed compared to the previous year, review changes for reasonableness. If the same risk score was used for both years, make sure the risk characteristics are the same. Document any findings. _____ _____

6. MMA audit steps:

   a. Trace the payment rates used in supporting documentation to calculate the new APR to the new MMA rates on CMS' website. Verify changes in risk assumptions.

   b. Verify the additional payments were used in one or more of the 5 ways identified in Section I.

   c. If the M+CO use the additional payments to "stabilize or enhance access to providers", obtain and review documentation supporting this use (e.g., provider contracts, support for revised unit cost and/or utilization).

   d. Determine if changes to values in the ACR have appropriate justification.

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SECTION V: WORKSHEET B – BASE PERIOD COSTS, REVENUE AND ENROLLMENT

BACKGROUND:

Information reported on Worksheet B is based primarily on the actual costs incurred by the M+C organization, any cost sharing collected or assumed to be collected, total revenue incurred, and enrolled member months for the base period of the ACR. CMS expects data for Worksheet B to be developed from actual costs reported by the M+C organization's accrual based general ledger or claims system and be traceable to a GAAP based financial statement, on a per-member, per-month (PMPM) basis. The methodology employed by the M+C organization will be unique to the individual organization and will be based on the M+C organization management's assertion that the information presented is cost data reported by the M+C organization's books of account and systems of internal control. *Exception:* The data required on coordination of benefits (COB) for Medicare generally should not require actual data. See Item 3 below. Furthermore, base period costs will reflect the base period service area of the plan priced in the ACR. Previously, CMS asked M+CO's to adjust the base-period costs to reflect the contract-year service area of the plan. Prior CMS approval of component grouping methodology is no longer required, but inclusion of a detailed description of the grouping methodology is required.

In addition:

1. With respect to column b (Medicare-Covered Benefits), column c (Additional Benefits), column d (Mandatory Supplemental Benefits), and column e (Optional Supplemental Benefits), the data for 2 or more columns may not be combined in one column. However, grouping of categories is allowed and a detailed description of any grouping methodology is required.

2. Lines 1-18 should include cost sharing charged or assumed to be collected for those benefits.

3. COB-Working Medicare and COB-Other must represent what the M+CO was entitled to collect from the enrollee and the primary payer when Medicare was the secondary payer for a service.

4. Base period data should be shown under the appropriate column for the contract year. Base period costs will reflect the base period service area of the plan priced in the ACR. Previously, CMS asked M+CO's to adjust the base-period costs to reflect the contract-year service area.

5. Line 29 represents amounts collected by the M+C organization from enrollees or on the behalf of enrollees in the form of premiums, cost sharing, as well as collections from CMS. This line should not include COB or the payment received from CMS.

6. If a plan had no Medicare enrollees in the base period, its Worksheet B should be blank.

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AUDIT OBJECTIVES:

1. To test management's assertions that the data reported on Worksheet B agrees with or is based upon the full costs reported in the M+C organization's books of account.

2. To test management's assertion that the direct medical and administration cost methodologies used are based on concepts supported by generally accepted accounting principles (GAAP).

3. To ensure the premium collected in the base period did not exceed the premium amount approved by CMS.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. Prepare a detailed report describing the costing methodology employed by the M+C organization to substantiate the information reported on Worksheet B.	_____	_____
2. Trace the cost information reported on Worksheet B to the M+C organization's general ledger. Document differences.	_____	_____
3. Trace the cost sharing information reported on Worksheet B to supporting documentation. If the M+CO does not have record of the actual amounts collected, then verify the reasonableness of the estimates. Verify that the amounts collected or estimated are consistent with the amounts described in the Plan Benefit Package (PBP) for the base period.	_____	_____
4. Trace total direct medical care and administration for all plans offered by the M+C organization to the M+C organization's certified financial statements. If the M+C organization does not have certified GAAP financial statements, then obtain a reconciliation tracing the information in the certified statements to GAAP standards and then to the individual ACRs. Administration may include any cost of doing business (e.g., income taxes, goodwill, royalties). Document differences.	_____	_____
5. With respect to lines 1-28, column b (Medicare-Covered Benefits), column c (Additional Benefits), column d (Mandatory Supplemental Benefits), and column e (Optional Supplemental Benefits), the data for 2 or more columns may not be combined in one column. However, grouping of categories is allowed and a detailed description of any grouping methodology is required. If the data in any of those columns had to be apportioned because of the lack of accounting data, verify the apportionment methodology. Pay close attention to instances where there is a small benefit cost, but large administrative or additional revenue amounts. Document findings.	_____	_____

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6. Ensure the coordination of benefits amounts on lines 20 and 21 are reported as described in item number 3 of the Background section. If the claims system aggressively identifies claims that may deem the M+CO a secondary payer, document these observations and do not list this as a finding. (An example of an aggressive system is one that flags claims with diagnoses common to automobile accidents or workman's compensation injuries or flags claims for members with other health insurance.) _____ _____

7. Verify that line 29 includes all premiums collected and cost sharing that should have been collected from enrollees (or collected on behalf of enrollees from sources such as employer groups) and also includes capitation payments received from CMS. In addition, premiums and cost sharing charged for extra benefits only offered to employer groups must be excluded. _____ _____

8. Confirm that reinsurance premiums and reinsurance recoveries are reported separately in their respective lines. _____ _____

9. Ensure that base period costs do not include "extra" benefits offered only to employer groups. _____ _____

10. Document instances where an M+CO did not follow CMS's instructions with respect to the items discussed above, even though any reported ACR values were not materially affected. _____ _____

11. Verify that the IBNR is reasonable based on the actual run out of claims and expenses. _____ _____

12. Optional procedures, if any:

    CMS representatives may request that specific tests be performed to develop findings in greater detail. Document these additional procedures, if any, including CMS's rationale and objectives for performing the additional procedures. _____ _____

13. MMA Audit Steps

    a. Verify that no changes have been made. Note instances where CMS approved changes in Worksheet B.

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SECTION VI: WORKSHEET C – PREMIUMS & COST SHARING

BACKGROUND:

Worksheet C reports the premiums and actuarial value of cost sharing for the M+C organization's plan on a per-member, per-month basis for the contract year. In addition:

1. Columns a through c report the actuarial value of cost sharing for Medicare-covered benefits, additional benefits and mandatory supplemental benefits, respectively.

2. Columns a and c of line 26 are the total premium to be charged to Medicare enrollees for basic benefits and mandatory supplemental benefits.

AUDIT OBJECTIVES:

To determine whether the cost sharing estimates represent reasonable projections of the experience to be expected in the Contract period.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. After a review of the documentation submitted by the M+CO with the ACR, prepare a request to the M+CO for such additional information as needed to carry out the audit procedures of this section. *Note: It is not necessary that the actuary be on-site during the "survey" phase of the audit.*	_____	_____
2. Using the documentation submitted, ensure that the per-service cost sharing assumptions are consistent with the comparable figures found in the Plan Benefit Package (PBP). Document instances where there are inconsistencies.	_____	_____
3. Determine if the cost sharing projections in Worksheet C are reasonable, individually, and in aggregate.		
a. Review should take into consideration:		
i. Per-service cost sharing assumptions.		
ii. Recent plan experience.		
iii. Trend in utilization and other residual sources.		
iv. Limits on enrollee out-of-pocket expenditures.		
v. Other information available to the actuary, including, but not limited to, industry experience adjusted for specific plan characteristics.		
vi. For Employer Group Health Plans, determine if the Actuarial Swapping/Equivalence of Benefits as outlined in the CMS Supplemental ACR Instructions dated March 5, 2002, is (are) reasonable.		
vii. The appropriate Actuarial Standards of Practice (ASOP), especially applicable sections of ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*. *Caution: The M+COs are not responsible for developing health filings that*	_____	_____

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AUDIT PROCEDURES:	Initial & Date	W/P Ref.
meet the standards of ASOP No. 8, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what procedures and assumptions were employed in the development of the ACR, and how these compare to those contained in the ASOPs.		
b. The actuary should document instances where the cost sharing projections are determined not to be reasonable. Documentation should include the actuary's best estimate of the cost sharing liability and the resulting impact on the ACR projection.		
4. Prepare a section of the Actuarial Report covering the ACR projections of enrollee cost sharing as defined in Section IX, Completion of the Examination, of these guidelines.	_____	_____
5. MMA changes		
a. Determine if changes to values in the ACR have appropriate justification.		

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SECTION VII: WORKSHEET D - EXPECTED COST & VARIATION

BACKGROUND:

Worksheet D reports the trended value of the benefit costs (costs on worksheet B multiplied by the trend from Worksheet A) and adjustments (expected variations) needed to cause the ACR computation to more closely approximate the costs to be incurred for the Medicare population during the contract period. The adjustments may include changes in Medicare coverage since the base period, projected changes in trend considerations (e.g., inflation, technology, utilization) and corrections of errors in the formulae in the electronic ACR.

An M+C organization might not have had any non-Medicare enrollees in the base period and/or in the contract period. In addition, an M+C plan might not have had any Medicare enrollees in the base period. In those instances, the ACR worksheets will not compute trended values for the contract year. Instead, the organization should have entered the plan's contract year projections on Worksheet D as expected variations.

The review of Worksheet D will focus on the "adjusted value" entries, which represent the trended values plus the adjustments.

AUDIT OBJECTIVES:

1. To determine whether the direct medical care (DMC) "Adjusted Value" estimates represent reasonable projections of the experience to be expected in the Contract period.

2. To test management's assertion that the adjustments to administration and additional revenue entries are founded on reasonable financial assumptions and statistical data.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. After review of the documentation submitted by the M+CO with the ACR, prepare a request to the M+CO for such additional information as needed, to carry out the audit procedures of this section. *Note: It is not necessary that the actuary be on-site during the "survey" phase of the audit.*	_____	_____
2. Determine if the DMC "Adjusted Value" projections are reasonable, individually, and in aggregate.		
a. Review should take into consideration:		
i. Recent plan experience, adjusted for changes in plan benefits.		
ii. Trend in provider reimbursement, utilization, intensity, and other sources.		
iii. Consistency with cost sharing projections.		
iv. Other information available to the actuary, including, but not limited to, industry experience adjusted for specific plan characteristics.		
v. Reinsurance contracts.		
vi. For Employer Group Health Plans, determine if the Actuarial Swapping/Equivalence of Benefits as outlined in the CMS Supplemental ACR Instructions dated March 5, 2002, is (are) reasonable.		

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AUDIT PROCEDURES:	Initial & Date	W/P Ref.
vii. The appropriate Actuarial Standards of Practice (ASOP), especially applicable sections of ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*. *Caution: The M+CO's are not responsible for developing health filings that meet the standards of ASOP No. 8, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what procedures and assumptions were employed in the development of the ACR, and how these compare to those required by the ASOPs.*	_____	_____
b. The actuary should document instances where the DMC "Adjusted Value" projections are determined not to be reasonable. Documentation should include the actuary's best estimate of the DMC "Adjusted Value(s)" and the resulting impact on the ACR projection	_____	_____
3. Determine if the adjustments made to administration, if any, are reasonable and are made to more closely approximate the cost that would be incurred for the Medicare population during the ACR contract period. Document findings.	_____	_____
4. Determine if an increase in additional revenue has appropriate justification. Appropriate justification does not include "balancing of Worksheet E." Document findings.	_____	_____
5. Prepare a section of the Actuarial Report pertaining to the "Adjusted Value" components of Worksheet D as defined in Section IX, Completion of the Examination, of these guidelines.		_____
6. MMA changes		
a. Evaluate discount drug card expected variation for reasonableness.		
b. Determine if changes to values in the ACR have appropriate justification.		

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SECTION VIII: WORKSHEET F – ADJUSTED COMMUNITY RATE FOR OPTIONAL SUPPLEMENTAL BENEFITS

BACKGROUND:

Worksheet F reports the total projected price (expected medical cost less cost sharing plus administrative cost, and additional revenue), cost sharing, and premium for each optional supplemental benefit package.

The review of Worksheet F will focus on any supporting documentation regarding the calculation of the entries on Worksheet F.

AUDIT OBJECTIVE:

1. To determine whether the total projected price (as comprised of expected medical cost less cost sharing plus administrative cost, and additional revenue), cost sharing, and premium estimates represent reasonable projections of the experience to be expected in the Contract period.

2. To determine if the premium is appropriate relative to the actuarial value of the benefit and cost sharing provisions of each benefit package.

AUDIT PROCEDURES:	Initial & Date	W/P Ref.
1. After review of the documentation submitted by the M+CO with the ACR, prepare a request to the M+CO for such additional information as is need to carry out the audit procedures of this section. *Note: It is not necessary that the actuary be on-site during the "survey" phase of the audit.*	_____	_____
2. Determine if the components of the total projected price are reasonable for each benefit package, individually. a. Review should take into consideration: i. Recent plan experience, adjusted for changes in plan benefits. ii. Trend in provider reimbursement, utilization, intensity, and other sources. iii. Consistency with cost sharing projections. iv. Other information available to the actuary, including, but not limited to, industry experience adjusted for specific plan characteristics. v. Reinsurance contracts. vi. For Employer Group Health Plans, determine if the Actuarial Swapping/Equivalence of Benefits as outlined in the CMS Supplemental ACR Instructions dated March 5, 2002, is (are) reasonable. *vii.* The appropriate Actuarial Standards of Practice (ASOP),		
	_____	_____

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AUDIT PROCEDURES:	Initial & Date	W/P Ref.
especially applicable sections of ASOP No. 8, Regulatory Filings for Rates and Financial Projections for Health Plans. *Caution: The M+CO's are not responsible for developing health filings that meet the standards of ASOP No. 8, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what procedures and assumptions were employed in the development of the ACR, and how these compare to those required by the ASOPs.*		
b. The actuary should document instances where the projections are determined not to be reasonable. Documentation should include the actuary's best estimate of the appropriate estimates and the resulting impact on the ACR projection	_____	_____
3. Determine if the cost sharing estimates are appropriate relative to the benefit provisions of each benefit package.	_____	_____
4. Determine if the premium is appropriate relative to the benefit and cost sharing provisions of each benefit package.	_____	_____
5. Prepare a section of the Actuarial Report pertaining to the components of Worksheet F as defined in Section IX, Completion of the Examination, of these guidelines.	_____	_____

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SECTION IX: COMPLETION OF THE EXAMINATION

OBJECTIVES:

1. To document the completion of the examination, adhere to the auditors' quality control procedures, and communicate the audit findings to CMS and the M+C organization.

2. To indicate clearly, if possible, the extent to which an ACR would be affected by changes needed to make it both reasonable and in synch with CMS policies and instructions.

PROCEDURES:	Initial & Date	W/P Ref.
1. Notify CMS if the auditor(s) suspects fraud by the M+C organization.	_____	_____
2. Determine if changes to values in the ACR to reflect MMA updated unit cost, utilization, and membership assumptions have appropriate justification.		
3. Prepare a report issuing an opinion on the reasonableness of the ACR worksheets. Using the model report format, advise CMS of the results of the procedures performed, summarizing all findings and observations, and the dollar amount of those findings, if possible. Policy issues should not be included in the report, but instead should be in a letter under separate cover. For findings where the effect cannot be quantified, include an explanation as to why. Minor modifications to the model report format are permissible to meet specific needs, but must have CMS approval first.	_____	_____
4. The Actuary is required to prepare an Actuarial Report that communicates the actuary's professional conclusions and recommendations regarding the reasonableness of projections contained in Worksheet C, D and F (if applicable). The actuary should also assist the auditor in ascertaining that the enrollment projections and risk projections in Worksheet A1, the apportionment method used to allocate benefits in Worksheet B, the reasonableness of the IBNR projections in Worksheet B, and the cost sharing estimates both in Worksheets A & B are all appropriate.		
a. The report should conform to the appropriate Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. Particular emphasis should be placed on the following ASOPs:		
i. ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*. Particular focus should be placed on the sections dealing with the Recognition of Benefit Plan Provisions (Sec. 5.2), Consistency of Business Plan and Assumptions (5.3), Reasonableness of Assumptions (5.4), and Use of Past Experience to Project Future Results (5.5). *Caution: The M+COs are not responsible for developing health filings that*	_____	_____

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PROCEDURES:	Initial & Date	W/P Ref.

meet the standards of ASOP No. 8, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what procedures and assumptions were employed in the development of the ACR, and how these compare to those required by the ASOPs.

ii. ASOP No. 23, *Data Quality*, with emphasis on Section 5, Analysis of Issues and Recommended Practices, and Section 6, Communications and Disclosures. *Caution: The M+COs are not responsible for developing health filings that meet the standards of ASOP No. 23, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report on the selection and review of the data used in the development of the ACR, and how these compare to what is required by the ASOPs.*

b. The report should include a description of the method used by the M+CO to estimate the expenditures for benefits PMPM in the Contract period.

c. The report should include an assessment of the reasonableness of the 2003 average payment rate (APR), as reported on Worksheet A1. In their assessment of the reasonableness of the APR, the actuary shall consider the data, methodology, and assumptions used in its projection.

d. The report should include an assessment of the reasonableness of the ACR projection of Worksheet C enrollee cost sharing and Worksheet D "Adjusted Value" figures. This analysis is to be performed on both individual benefit categories, and on all benefit categories in their entirety. Such reasonableness should be determined using all information available to the actuary and the actuary's judgement. To the extent that estimates are determined to be unreasonable, the actuary is to report on their "best estimate" of the figure.

e. The report should compare the documentation maintained by the M+CO with the standards of ASOP No. 31, "Documentation in Health Benefit Plan Ratemaking". *Caution: The M+COs are not responsible for providing documentation that meets the standards of ASOP No. 31, and this should be clearly stated in the Actuarial Report. The objective is to investigate and report what documentation is maintained by the M+CO, and how this compares to what would be required by the ASOPs.*

4. Provide written notification of the date of the exit conference to the M+C organization and CMS. Also provide CMS and the M+C organization a written summary of the findings. Request that an initialed or acknowledged _____ _____

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CONTRACT YEAR: _____

PROCEDURES:	Initial & Date	W/P Ref.
copy be available at the exit conference.		
5. Obtain a signed letter of representation prior to the end of fieldwork and include this as an attachment to the report. Ensure that the M+C organization has not materially altered the model letter.	_____	_____
6. Conduct an exit conference:		
a. Prepare an agenda for the exit conference in advance to ensure that all relevant topics are covered.	_____	_____
b. Invite CMS to the exit conference.	_____	_____
c. Provide the agenda to the M+C organization's representatives (and to CMS's representative, if he or she is in attendance).	_____	_____
d. Hold an exit conference with the M+C organization's representatives.	_____	_____
e. Summarize the results of the exit conference in a memo. Include the names of the attendees.	_____	_____
7. Complete quality control documents:		
a. Disclosure checklist.	_____	_____
b. Reporting checklist.	_____	_____
c. Other checklists as appropriate.	_____	_____
8. Summarize the completion of the examination in a memorandum.	_____	_____
9. Issue an agree/disagree letter, using the model provided by CMS, to the M+C organization containing the list of findings/observations. Include this letter as an attachment to the report.	_____	_____
10. Prepare a table of contents that describes the contents of each work paper binder. Include a copy in each binder.	_____	_____
11. Arrange for the review of the work papers by the engagement manager, etc.	_____	_____
12. Arrange for the review of the work papers by the quality control manager, etc. (Professional Standards Review.)	_____	_____
13. Make work papers and other audit documentation readily available to CMS for review. Work papers should be maintained for at least 6 years. The work papers should only be submitted to CMS upon request.	_____	_____

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EXHIBIT A

Excerpt of 42 CFR 422.502(d), (e), and (f)
MMA proposes to re-designate existing 422.502 to 422.504.

(d) Maintenance of records. The M+C organization agrees to maintain for 6 year books, records, documents, and other evidence of accounting procedures and practices that—

(1) Are sufficient to the following:
- (i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the ACR) of M+C organization.
- (ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the organization.
- (iii) Enable CMS to audit and inspect any books and records of the M+C organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.
- (iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the ACR proposal.
- (v) Establish component rate of the ACR for determining additional and supplementary benefits.
- (vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchaser; and

(2) Include at least records of the following:
- (i) Ownership and operation of the M+C organization's financial, medical, and other record keeping systems.
- (ii) Financial statements for the current contract period and six prior periods.
- (iii) Federal income tax or information returns for the current period and six prior periods.
- (iv) Asset acquisition, lease, sale, or other action.
- (v) Agreements, contracts, and subcontracts.
- (vi) Franchise, marketing, and management agreements.
- (vii) Schedules of charges for the M+C organization's fee-for-service patients.
- (viii) Matters pertaining to costs of operations.
- (ix) Amounts of income received by source and payment.
- (x) Cash flow statements.
- (xi) Any financial report filed with other Federal programs or State authorities.

(e) Access to facilities and records. The M+C organization agrees to the following:

(1) HHS, the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;
(ii) The facilities of M+C organization; and
(iii) The enrollment and disenrollment records for the current contract period and six prior periods.

(2) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the M+C organization, related entity, contractor, subcontractor, or its transferees that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(3) The M+C organization agrees to make available, for the purposes specified in paragraph (d) of this section, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require.

(4) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 6 years from the final date of the contract period or completion of audit whichever is later unless—
(i) CMS determines there is a special need to retain a particular record or group of records for a long period and notices the M+C organization at least 30 days before the normal disposition date;
(ii) There has been a termination, dispute, or fraud or similar fault by the M+C organization, in which
(iii) Case the retention may be extended to 6 years from the date of any resulting final resolution of termination, dispute, or fraud or similar fault; or CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit the M+C organization at any time.

(f) Disclosure of information. The M+C organization agrees to submit—

(1) To CMS, certified financial information that must include the following:
(i) Such information as CMS may require demonstrating that the organization has a fiscally sound operation.
(ii) Such information as CMS may require pertaining to the disclosure of ownership and control of the M+C organization.

(2) To CMS, all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:
(i) The benefits covered under an M+C plan;
(ii) The M+C monthly basic beneficiary premium and M+C monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the M+C monthly MSA premium.

(iii) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(iv) Plan quality and performance indicators for the benefits under the plan including—

(A) Disenrollment rate for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(B) Information on Medicare enrollee satisfaction;

(C) Information on health outcomes;

(D) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(E) Other information determined by CMS to be necessary to assist beneficiaries in making informed choice among M+C plans and traditional Medicare;

(v) Information about beneficiary appeals and their disposition;

(vi) Information regarding all formal action reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(vii) For M+C organization offering an MSA plan, information specified by CMS for CMS's use in preparing its report to the Congress on the MSA demonstration, including data specified by CMS in the area of selection, use of preventive care, and access to services.

(viii) To CMS, any other information deemed necessary by CMS for the administration or evaluation of the Medicare program.

To its enrollees all informational requirements under Section 422.64 and, upon an enrollee's request, the financial disclosure information required under Section 422.516.